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A Mystery and an Enigma—Inez

Step 1

The police have brought a young woman to the emergency room. She carries no identification, and you know only that she has just been pulled from a car that was involved in a single-vehicle traffic accident. She wasn't driving; in fact, the driver is dead. No one else was in the car—a loaner from a car dealership.

You have only a few minutes to interview her: She must be moved to the operating room to stabilize her fractured pelvis. She speaks slowly, deliberately, in simple sentences; her pronunciation is clear. Her speech is coherent, but it conveys remarkably little information: She responds to most questions with "I don't know," or, occasionally, she simply doesn't respond at all. Her only spontaneous request is "I want my mom." During the interview, such as it is, she keeps her gaze firmly fixed on you. Her speech is a bit circumstantial; should we call it tangential? There's a bruise on the side of her head. Her pupils are equal. Her affect is uniformly flat.

Inez has a nearly empty pill bottle in her pocket; it bears no label, and no one in the emergency room recognizes the remaining tablets. No purse or wallet accompanies her from the scene of the accident. From her demeanor and speech, you can't determine enough to decide whether she needs further evaluation before she goes into surgery. Time is of the essence; besides surgery for her fractured pelvis, she needs to be evaluated for possible internal bleeding.

Right from the opening seconds of the interview, experienced clinicians start to compile a list of possible causes for what they observe. Based on what we've observed in Inez so far—slow speech, a paucity of information in her thought content, dull affect—what would be on your list of conditions to rule out? Write them down, and then compare them with mine in Note A. I'm betting that at least one of mine will surprise you.

Note A

Here's my list of disorders in which we could expect to encounter a combination of dull affect, limited content of thought, and slow speech.

- Traumatic brain injury with delirium
- Substance/medication-induced depressive disorder
- Substance intoxication
- Schizophrenia (and other psychotic disorders, such as schizophreniform disorder)
- Major depressive disorder (and other mood disorders)
- Autism spectrum disorder
- Intellectual disability (ID)

I wouldn't call this list a differential diagnosis. Rather, it's a game plan for how to approach someone with Inez's special requirements. It will inform your interview with the patient over the next 30 minutes, or whatever time you have before they haul her off to surgery.

I thought that the inclusion of ID might surprise you. That's because, though it is one of the most common mental conditions on the face of the earth (to one degree or another, it affects 3% of the overall population), the majority of people affected by it look no different from anyone else. That allows this diagnosis sometimes to fly undetected beneath our diagnostic radar.

Of course, Inez's final diagnosis may not even be on our initial list. Perhaps we haven't yet observed the behaviors that would lead us to the correct diagnosis. But the conditions listed are the ones that should guide us as we pursue our interview with her.

Rant

Intellectual disability (ID) is the current term of choice for what was once called *mental retardation.* For a little over 100 years, that term (or the single word *retardation*) was used as a description of intellect. As such, it once comprised a number of other, even less desirable terms: *idiot, imbecile, moron*—each of which was supposed to denote a specific IQ range. These pejoratives are well behind us now, for which we can be grateful, but the "R word" is still with us—recently as an epithet of abuse in popular film and literature, and, way too often, in personal discourse. Rosa's Law was named for then 9-year-old Rosa Marcellino, who has Down syndrome and with her family worked to replace *mental*

retardation in law with *intellectual disability*. They succeeded, first in their own state of Maryland, then nationally; President Barack Obama signed it into law in 2010.

However, even beyond semantics, there remains the problem of precision. The strict meaning of the term *retarded*—"slowed down"—suggests a person who is intellectually running behind now, but who might catch up later. Of course, the vast majority of affected people will never truly catch up, though they may, with education, coaching, and accommodation, come to compensate in part for their condition. ID is currently defined not on the basis of raw intelligence alone, but also on the degree to which the individual's adaptive functioning is impaired. A rival term, *intellectual developmental disorder* (IDD), currently used in the 11th revision of the *International Classification of Diseases* (ICD-11), and as an alternative term to ID in DSM-5, further underscores the fact that the cognitive deficits begin early in the developmental period. With their emphasis on the degree to which affected persons can compensate for their disability, either of these terms is a vast improvement on the old definition of mental retardation.

Whichever of these two terms we use, we are engaged in an effort that goes beyond a simple, though laudable, effort to achieve political correctness. Even well into the 21st century, we are still in the process of learning to describe mental disorder in general, and ID in particular, in ways that are both accurate and useful.

Step 2

Inez is still lying on a gurney in the emergency room, awaiting transport to the operating room. You stand at her side, armed with your tentative list of the mental problems she might have. Now you must rapidly work your way through them, selecting open-ended and closed-ended questions to complete the task.

Time management means that you will need to consider the advantages of closed-ended questions as opposed to open-ended ones. We've talked a bit about this earlier in Step 1 and Note A of Elinor's story (Chapter 5, page 56). Now let's identify the characteristics of each type of question. I've tried to make it easy by listing many of the features of each type. After each question, just circle the O or the C for open-ended or closed-ended, respectively.

- You can spend more time listening. O/C
- Answers take just a few words. O/C
- You can obtain a broader scope of information. O/C
- It discourages evasiveness. O/C
- It facilitates expression of feelings. O/C
- It's generally used early in an interview. O/C
- It's generally used later in an interview. O/C
- It helps establish rapport. O/C
- It can elicit significant negatives. O/C
- It helps pin down a diagnosis. O/C
- It may suggest an answer the patient thinks you want to hear. O/C
- It requires longer answers. O/C
- It's useful for clarifying an earlier response. O/C

- It helps obtain details about an event or emotion. O/C
- The information it yields tends to be valid. O/C
- It can yield a broad range of concerns from the patient. O/C
- It may help you cut to the chase when time is of the essence. O/C
- You may want to shift to this type when the other type hasn't been very successful. O/C

After you've tagged each characteristic, which type of question points the way for your further evaluation of Inez?

Note B

Here are my answers to the features of open-ended (O) and closed-ended (C) questions:

- You can spend more time listening. O
- Answers take just a few words. C
- You can obtain a broader scope of information. O
- It discourages evasiveness. C
- It facilitates expression of feelings. O
- It's generally used early in an interview. O
- It's generally used later in an interview. C
- It helps establish rapport. O
- It can elicit significant negatives. C
- It helps pin down a diagnosis. C
- It may suggest an answer the patient thinks you want to hear. C
- It requires longer answers. O
- It's useful for clarifying an earlier response. C
- It helps obtain details about an event or emotion. C
- The information it yields tends to be valid. O
- It can yield a broad range of concerns from the patient. O
- It may help you cut to the chase when time is of the essence. C
- You may want to shift to this type when the other type hasn't been very successful. C

Adding up the O's and C's yields many features in favor of each type. Considering what we've encountered so far in Inez, who doesn't show a lot of spontaneity anyway, the last item in the list is the clincher: it suggests that, for the present, you will be more successful with questions that are generally closed-ended. And that judgment is reinforced by the strictures of time, as noted in the next-to-last item in the list.

By the way, time management is one of two main uses of the closed-ended question. Keep reading; before too long, we'll encounter another use.

Step 3

Considering our tentative list of conditions to explore and the fact that our time with Inez is limited, what closed-ended question should we choose to start off in the right direction? I'll offer some alternatives:

- ☐ "How are you feeling right now—happy, sad, something else?"
- ☐ "Have you had any experiences such as hearing voices when no one was talking, or seeing things that other people couldn't see?"
- ☐ "Will you tell me your name?"

Note C

My answer (no, my *question*) would be the third choice. Of course, we already know her name—but the question serves as a proxy for the entirety of the formal mental status evaluation (MSE). Here's why I think we should focus on it with Inez:

We already have some indication that Inez's brain may not be working as well as it should, and we know that she has very recently been in an accident. Furthermore, we don't have a baseline against which to assess change in mental functioning. Outside information from a friend or relative would probably help us with some of these issues, but we don't have the luxury of that resource. Instead, I'd move right away to a careful appraisal of her current cognitive functioning.

Step 4

Just below is the outline of *cognitive* features we usually include in an MSE. We'll use the check boxes once we get to the end of this Step.

Orientation
- ☐ Person
- ☐ Place
- ☐ Time

Memory
- ☐ Immediate
- ☐ Recent
- ☐ Remote

Attention and concentration
- ☐ Serial sevens
- ☐ Counting backward

Cultural information
- ☐ Examples: recent presidents/prime ministers, state governors or provincial prime ministers

Abstract thinking
- ☐ Similarities
- ☐ Differences

Insight and judgment
- ☐ Insight
- ☐ Judgment

And here, with Inez's responses, are the MSE questions that pertain to cognition. To give the flavor of the whole interview, I've written out the exchange verbatim, adding in the occasional comment. At the end, I'm going to ask you to evaluate her cognitive status.

Q: I'd like to ask you some routine questions to help me understand what sort of problem you might be having.

A: (*No answer*)

Q: Will you tell me your name?

A: (*After a few moments' pause*) It's Inez.

Q: Great! And your last name?

A: Inez Paisley.

Q: Super! My name is (*you give it*). Will you please repeat it back right now?

A: (*She accurately repeats your name.*)

Q: Excellent! And can you tell me what the date is today?

A: I don't know.

Q: Well, how about just the month?

A: Um, maybe October?

Q: That's right. Very good! Now how about the date?

A: I don't know.

Q: OK, is it early in the month?

A: Halloween's coming.

Q: You are right about that! Is Halloween coming soon?

A: I think so. Day after tomorrow. I've bought candy.

Q: So what would be the day of the month today?

A: (*Long pause*) October 29th.

Q: And the year?

A: (*After one false start, she corrects herself and then states it correctly.*)

Q: Perfect! And do you know where you are right now?

A: I don't know—a hospital?

Q: Yes, this is a hospital emergency room. Do you know the name of this hospital?

A: No.

Q: What city are we in?

A: (*After a pause, she gives the correct answer.*)

Q: Excellent! Now I'm wondering: Do you feel up for a little math? We clinicians are always asking people to do math problems. It's just part of the routine.

A: I don't know. I'm not very good at math.

Q: Well, let's just give it a try. Can you subtract 7 from 100?

A: I can with a pencil. And paper. (*Long pause*)

Q: OK, instead, can you just count backward from 30 and stop when you get to 15?

A: Um, 30, 29 . . . ?

Q: Great! Keep going to 15.

A: 30, 29, 28 . . . (*She keeps counting until she gets to 15, then stops.*)

Q: Excellent! Now let's try something different. Would you multiply 2 times 3?

A: That's 6.

Q. Great. Now 2 times 6?

A: Um . . . 12.

Q: Good. Can you keep going?

A: Going where?

Q: Well, 2 times 12.

A: (*Pause*) 24?

Q: Good. And 2 times 24?

A: (*Long pause*) No, that's too hard.

Q: OK. Let's try something that isn't math. What does it mean when I say, "Don't cry over spilt milk"?

A: Well, if you spill the milk, you shouldn't cry about it.

Q: Right. But does it have any other meaning?

A: Just, don't spill the milk.

Q: OK, and what did I tell you my name is?

A: (*After a pause, Inez states it correctly.*)

Q: Do you know what's happened to you? I mean, why you are here?

A: Well, I was riding in the car.

Q: Yes, and what happened?

A: I think I hit my head. And my leg hurts, up here. (*She points to her hip.*)

Q: That's right; it got broken in an accident. Do you want the doctors to fix it? It means an operation.

A: I want it well again.

Q: Do you think you should have the operation?

A: If that will fix it, sure.

Given the information we have so far, please go back and make a checkmark beside each indicator of cognitive status in the list at the beginning of this Step for which we have at least a modest amount of information.

Note D

With only a start on the MSE, and hardly any history at all, we've actually accomplished quite a lot. Perhaps in response to encouragements and overt praise, Inez is now talking more than she did at first, and she's demonstrated that she's fully oriented to person, place, and time. Furthermore, she can focus pretty well—she's paid attention through several minutes (12 by actual count) of formal testing, and throughout a countdown to stop at a specific number. She has also retained a name and repeated it after more than 5 minutes, so her short-term memory is intact. However, she doesn't appear able to abstract a general principle from a proverb. Even though we haven't evaluated her store of cultural information or her insight and judgment, what Inez has demonstrated is a far better cognitive performance overall than we might expect from someone with, for example, delirium from head trauma.

Step 5

How would you evaluate Inez's differential diagnosis against the choices listed in Note A now? It would be a good thing, using those choices, to make a few notes here as to why you would favor or reject each one.

Note E

Brace yourself: I'm going to take my usual methodical stroll through the suggestions we have so far. Right now, the differential diagnosis stands as the temporary list we've formulated in Note A.

We've already mentioned the fact that Inez's cognitive status is more nearly intact than we'd expect from someone with a delirium. The criteria for delirium require problems with attention *and* orientation, and Inez appears to have neither. Reduced affective lability can of course be encountered in schizophrenia and other psychotic disorders, but we have so far

turned up no evidence of hallucinations or delusions. Furthermore, Inez's thinking, when she does speak, is pretty much linear and responsive to the line of questioning. In other words, we find no evidence that she has the sort of A criteria (we've discussed them for Brad in Chapter 2, page 26) that would be needed to diagnose a psychosis.

Both affect and content of thought can be restricted in mood conditions, such as a major depressive episode. We would have to dig for a lot more information—especially an expression of feeling depressed!—before we could diagnose a depressive disorder. Autism spectrum disorder can cause patients to have limited affect and difficulty relating to other people, but Inez appears to warm to the interview situation; we'd need a lot of historical information to sustain this diagnosis. People who are under the influence of alcohol or other substances sometimes have flattened affect and may offer limited responses to questions, but again, substance use in this case would require history that I don't think will be forthcoming.

So what about ID? It certainly fits with her presentation, and I'm betting that it will appear when we settle on her final diagnosis—but that'll be somewhat later. Right now, we cannot affirm ID, either: It requires information that her symptoms began in early childhood and that they have limited her ability to be socially and personally independent. What we do have so far is consistent with mild ID, but this is a diagnosis for which there is no effective treatment, so we must be certain of our ground before lumbering Inez with the label. We simply cannot justify making this diagnosis without more information.

Uh-oh: For one reason or another, we've rejected every potential diagnosis on our list. Where does this leave us? Without enough material to make any solid diagnosis, her formal diagnosis at this point would have to be *undiagnosed*.

And we would tell anyone with a need to know—especially the surgeons—that with the present information, her diagnosis is most consistent with mild ID. Period.

Rant

Let's stipulate, for the sake of discussion, that Inez has mild ID. Obviously, it began when she was an infant—probably even before she was born. Hers is only one of the disorders that we sometimes forget to consider, because we tend to think of them as "kids' diseases." Yet diagnoses such as ID and certain others that are usually made in childhood continue to follow affected patients throughout their lives. These conditions include autism spectrum disorder, Tourette's disorder, and learning disorders, which are generally first diagnosed in childhood (or sometimes the teen years) but persist into adulthood. Others, such as separation anxiety disorder, reactive attachment disorder, and pica, were once included in the section of the diagnostic manuals devoted to what are now called *neurodevelopmental disorders*. Still other disorders are clearly intended to be applied to children, but are listed in sections of the manuals specific to behavior rather than to age (the brand-new DSM-5 diagnosis of disruptive mood dysregulation disorder is the obvious example).

When determining a differential diagnosis, we need to keep in mind so-called "childhood disorders" that persist. In the second edition of *Interviewing Children and Adolescents,* Kathryn Flegel and I have included an appendix that lists every major mental disorder (omitting the paraphilias), with our estimation of the earliest age at which each one might be reported to occur, as well as the period of life

that it might most often be found. Of 110 disorders, we've reckoned that only 5 would never occur for the first time in children: 4 neurocognitive disorders (still commonly called dementias when they are major), plus rapid eye movement sleep behavior disorder. To be sure, 70 are most often encountered in adults (or, in some cases, youth in their late adolescence). But the bottom line is this: Very few of the conditions we discuss in our differential diagnoses are exclusive either to adults or to children/teenagers. Clinicians who work with patients of any age range need to be aware of the full spectrum of mental disorders, regardless of the typical age at which the disorders are first encountered.

Step 6

Inez is about to have a further diagnostic workup, followed by surgical care. Don't we need to consider whether she has the ability to give informed consent?

Let's review the traditional guidelines for judging whether a patient's consent to a medical procedure is appropriately informed:

1. Sufficient maturity. Children are too young to have the perspective and judgment required for the evaluation of health care issues; by the time they are in their mid- to late teens, this capacity has usually developed sufficiently, but the determination must be made case by case.
2. Ability to appreciate the consequences of the procedure and the possible outcome if it is not performed. Adults are presumed to have this capacity, in the absence of marked ID or other mental or emotional disorder.
3. Consent freely given. This means that there must be (a) no coercion employed and (b) adequate time for considered reflection, if possible. However, some situations are emergent and must be rapidly evaluated and decided upon.
4. Clinician candor. Especially in circumstances such as research studies, it is also important that the patient be apprised of any possible conflict of interest the clinician might have.

On the basis of these guidelines, and considering what we know about Inez, how would you evaluate her capacity to consent to an operation on her hip? If we need more information to make this determination, what would that be?

Note F

Of course, Inez is old enough to make this sort of decision, and there is no evidence to suggest that she is in any way being coerced. Rather, the issue has to do with her ability to understand the fact that she requires surgery. Quite frankly, I'd feel a little more secure if we'd taken the time to ask, "Do you understand that sometimes surgery can go wrong and people can get even sicker?" But, given her absolute need for the procedure and the fact that there's no one available to act as her proxy, I believe we should allow her to sign for her own care.

The Takeaway

In Inez, we've encountered a time-limited situation with a patient who doesn't spontaneously offer much information; this has forced us to rely heavily on closed-answer questions. We've discussed her likely diagnosis of mild ID; despite its ubiquity, it is easy to overlook. However, lacking the necessary collateral information, we must ultimately fall back on the diagnostic principle that advises us to use the term *undiagnosed* when we are unsure of the diagnosis. We have also discussed what steps we should take to ensure that a patient is competent to give informed consent for a medical procedure.

Break Time

Who doesn't like free stuff? As I've noted in an earlier Break Time, there are a lot of great reads you can download just for the asking from Project Gutenberg and other free sites. Some of these books feature characters with mental health issues, and some of *them* make for interesting diagnostic problems.

One such is the central character of Herman Melville's classic short story "Bartleby, the Scrivener." First published in 1853 and subtitled "A Story of Wall-Street," it concerns the new clerk (Melville gives him no first name) hired by the narrator, a Wall Street lawyer (who remains totally nameless throughout). Bartleby is initially hard-working and productive, but he later comes to answer every request with the refrain "I would prefer not to." And indeed, as time goes by, he accomplishes less and less, eventually spending his days staring at the brick wall visible from his office window. Ultimately he prefers not even to eat and dies of starvation. I'm not going to tell you more. But I will say this: At the end, there is considerable doubt as to just what is the matter with Bartleby.

You can approach this Break Time in a manner that's about as quick, or perhaps as slow, as you wish. (OK, the absolute speediest method is to stop reading now and skip to Chapter 10. Absent this back-of-your-hand dismissal, you can just read "Bartleby" as an interesting story that you may not have encountered before.)

But if you do engage in this experiment, the story itself will be a quick read (at 14,000 words, you can probably knock it off in an hour). Go ahead and download it from the Project Gutenberg website, and then—as so many clinicians find themselves compelled to do when they read the classics of literature—try to figure out just what ails Bartleby. You can even construct a differential diagnosis. And if your interest has been truly piqued, you can visit my website to see what I think about Bartleby's condition, and what lessons his story might hold for us today. You may end up agreeing with the narrator, who in the last line of the story sighs, "Ah Bartleby! Ah humanity!"

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